DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To:	All Medical Providers Managed Care Organizations	**Memorandum No: 06-41** **Issued:** June 29, 2006
From:	Douglas Porter, Assistant Secretary Health and Recovery Services Administration (HRSA)	**For information, contact:** 800.562.3022 or go to: http://maa.dshs.wa.gov/contact/prucontact.asp

Subject: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): Fee Schedule Changes

Effective for dates of service on and after July 1, 2006, the Health and Recovery Services Administration (HRSA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2006 relative value units (RVUs);
- The updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- The updated injectable drugs and change vaccine coverage;
- The updated Medicare Average Sale Price (ASP) drug files;
- The technical changes listed in this numbered memorandum; and
- A one percent (1%) vendor rate increase.

Maximum Allowable Fees

HRSA is updating the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) fee schedule with Year 2006 RVUs, clinical laboratory fees, and Medicare ASP pricing. The 2006 Washington State Legislature appropriated a vendor rate increase of one percent (1%) for the 2007 state fiscal year. The maximum allowable fees have been adjusted to reflect these changes.

Visit HRSA's website at http://maa.dshs.wa.gov. To view a current fee schedule, click ***Provider Publications/Fee Schedules***, then ***Accept***, then ***Fee Schedules***.

Bill HRSA your usual and customary charge.

Injectable Drug Updates

HRSA updates the maximum allowable fees for injectable drugs on a quarterly basis. Current and past fee schedules are posted on HRSA's website at http://maa.dshs.wa.gov (click ***Provider Publications/Fee Schedules***, then ***Accept***, then ***Fee Schedules***). All fees have been updated at 106% of the Average Sales Price (ASP) as defined by Medicare. If a Medicare fee is unavailable for a particular drug, HRSA prices the drug at 86% of the Average Wholesale Price (AWP).

Immunization Update

HRSA no longer covers the following vaccine code. Please bill the appropriate single vaccine:

Procedure Code	Brief Description
90748	Hep b/hib vaccine, im

Note: If an immunization is the only service provided, you must bill only for the administration of the vaccine and the vaccine itself (if appropriate). You must not bill an Evaluation and Management (E&M) procedure unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M with modifier 25. If you bill an E&M on the same date of service as a vaccine administration without modifier 25, HRSA will deny the E&M service.

Retroactive to dates of service on and after January 1, 2006, CPT® code 90712 is no longer available through the Universal Vaccine Distribution program and the Federal Vaccines for Children program.

HRSA no longer uses shading to identify vaccines that are free from the Department of Health (DOH). These vaccines are now identified in the "Comments" column of the Fee Schedule as "free from DOH."

Effective for dates of service on and after July 1, 2006, HRSA pays $5.96 for the administration of those vaccines that are free from DOH and are billed with modifier SL (e.g., 90707 SL).

Health Departments

HRSA no longer pays health departments for CPT code 99211 when an immunization is the only service provided. HRSA pays health departments for the appropriate immunization code and administration code. However, if the vaccine is available free from DOH, HRSA pays for the administration **only.** The vaccine must be billed with modifier SL.

Genetic Testing

For laboratories billing for genetic testing, the provider ordering the genetic test must give the laboratory the following:

- A prior authorization (PA) number for the laboratory test (if applicable); and
- The correct CPT genetic testing modifier to indicate the purpose of the test.

EPSDT Updates (*Foster Care Children)*

DSHS updated the "other" column of the Medical ID Card by adding one of the following letters to indicate the child is in foster care:

- **D** (Division of Developmental Disabilities client in relative placement);
- **F** (Foster Care placement); or
- **R** (Relative placement).

HRSA pays providers an enhanced flat fee of $120.00 per EPSDT screening exam for foster care clients who receive their medical services through HRSA's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

Effective for dates of service on and after July 1, 2006, if the Medical ID Card indicates one of the above letters, the provider may bill one of the above screening codes with modifier 21 to receive the enhanced rate.

HRSA pays providers for EPSDT screening exams for foster care clients without regard to the periodicity schedule when the screening exams are billed using modifier 21.

Place of Service

Reminder: Effective July 1, 2006, all claims submitted to HRSA must include the appropriate Medicare **two-digit place of service code.** Claims with a single-digit place of service code will be denied. See Numbered Memorandum 06-26 for previous notification of this change.

National Correct Coding Initiative

HRSA continues to implement the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists HRSA to control improper coding that may lead to inappropriate payment. HRSA bases coding policies on:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual;
- National and local policies and edits;
- Coding guidelines developed by national professional societies;
- The analysis and review of standard medical and surgical practices; and
- Review of current coding practices.

HRSA may perform a post-pay review on any claim to ensure compliance with NCCI. Visit the NCCI on the web at http://www.cms.hhs.gov/physicians/cciedits.

Billing Instructions Replacement Pages

Attached are updated replacement pages C.1-C.4, C.7-C.10, D.7-D.8, E.1-E.6 (replaces E.1-E.10), and a new Appendix for HRSA's current *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Billing Instructions*.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing the WAMedWeb at http://wamedweb.acs-inc.com.

How can I get HRSA's provider documents?

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at http://maa.dshs.wa.gov (click on the ***Billing Instructions/Numbered Memoranda*** or ***Provider Publications/Fee Schedules*** **link**).

To request a free paper copy from the Department of Printing:

1. **Go to: http://www.prt.wa.gov/** (Orders filled daily.)

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Health and Recovery Services Administration*.**

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Document Correction***. You will then need to select a year and then select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/telephone 360.586.6360. (Orders may take up to 2 weeks to fill.)

EPSDT Screening Components

What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

What is included in an EPSDT screening?

At a minimum, EPSDT screenings must include, but are not limited to:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment, including:
  - ✓ How to clean teeth as they erupt.
  - ✓ How to prevent baby bottle tooth decay.
  - ✓ How to look for dental disease.
  - ✓ Information on how dental disease is contracted.
  - ✓ Preventive sealant.
  - ✓ Application of fluoride varnish, when appropriate.
- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

These components may be performed separately by licensed providers; however, HRSA encourages the provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

Additional Screening Components:

For fee-for-service clients, the following screening services may be billed in addition to the EPSDT screening codes listed on the previous page:

- Appropriate audiometric tests (CPT® codes 92552 and 92553);
- Appropriate laboratory tests, including testing for anemia; and
- Appropriate testing for blood lead poisoning in children in high-risk environments (CPT codes 82135, 83655, 84202, and 84203).

How often should EPSDT screenings occur?

The following are Washington State's schedules for health screening visits. Payment is limited to the recommended schedules listed below:

- Five total screenings during the first year of the child's life. Below is a recommended screening schedule for children from birth to one year of age.
  - ✓ 1st Screening: Birth to 6 weeks old
  - ✓ 2nd Screening: 2 to 3 months old
  - ✓ 3rd Screening: 4 to 5 months old
  - ✓ 4th Screening: 6 to 7 months old
  - ✓ 5th Screening: 9 to 11 months old
- Three screening examinations are recommended between the ages of 1 and 2 years.
- One screening examination is recommended per 12-month period for children ages 2 through 6.
- One screening examination is recommended per 24-month period for children ages 7 through 20, except foster care clients, who receive a screening examination every 12 months and within 30 days of foster care placement or official relative placement through the Children's Administration.

Foster Care Children

Foster care is defined as:

Twenty-four hour per day temporary substitute care for a child placed away from the child's parents or guardians in licensed, paid, out-of-home care, and for whom the Department or a licensed or certified child placement agency has placement and care responsibility.

DSHS updated the "other" column of the Medical ID Card by adding one of the following letters to indicate the child is in foster care:

- **D** (DDD client in relative placement);
- **F** (Foster Care placement); or
- **R** (Relative placement).

HRSA pays providers an enhanced flat fee of $120.00 per EPSDT screening exam for foster care clients who receive their medical services through HRSA's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

Effective for dates of service on and after July 1, 2006, if the Medical ID card indicates the child is in foster care, the provider must bill one of the above screening codes with modifier 21 to receive the enhanced rate.

HRSA pays providers for an EPSDT screening exam for foster care clients without regard to the periodicity schedule when the screening exam is billed with modifier 21.

To receive the enhanced rate, providers are required to use either:

- The DSHS "Well Child Examination" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)]; **or**
- Another charting tool with equivalent information.

To obtain paper copies of the Well Child Examination forms, follow the instructions found on page C.10 of this section.

To download an electronic copy of the Well Child Examination form, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.

What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through…	For clients who are…	Must be scheduled within…
HRSA's Managed Care plans, Primary Care Case Management (PCCM), or Primary Care Providers (PCPs)	Infants – within the first 2 years of life.	21 days of request.
	Children – two years and older.	Six weeks of request.
	Receiving Foster Care – Upon placement	30 days of request, or sooner for children younger than 2 years of age.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	Birth through 20 years of age	14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

What if a medical problem is identified during a screening examination?

If a medical problem is identified during a screening examination, the provider may:

- Refer the client to an appropriate provider for medical treatment; or
- Provide the service for the client (if it is within the provider's scope of practice).

Genetic Counseling and Genetic Testing

HRSA covers genetic counseling and genetic testing for pregnant women and postpartum women up to 90 days after delivery and infants up to 90 days after birth. This does not require PA for fee-for-service (FFS) clients or for clients on HRSA managed care plans. To locate the nearest DOH-approved genetic counselor call DOH at 253.395.6742.

HRSA covers genetic counseling for all FFS adults and children when performed by a physician.

To bill for genetic counseling, use diagnosis code V26.33 genetic counseling and the appropriate E&M code.

Certain genetic testing procedure codes need PA. Physicians- or HRSA-approved genetic counselors must obtain PA if required for certain genetic tests and must give both the PA number and the appropriate genetic testing modifier to the laboratory or when the laboratory bills so they can bill correctly.

Medical Nutrition Therapy

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

HRSA pays for the procedure codes listed below when referred by an EPSDT provider. **Providers must document beginning and ending times that the service was provided in the client's medical record.**

Procedure Code	Limitations
97802	1 unit = 15 minutes; maximum of 2 hours (8 units) per year
97803	1 unit = 15 minutes; maximum of 1 hour (4 units) per day
97804	1 unit = 15 minutes; maximum of 1 hour (4 units) per day

Fluoride Varnish (HCPCS code D1203)

Fluoride varnish is a type of topical fluoride that acts to retard, arrest, and reverse the caries process. It is applied up to three times per year to all surfaces of the teeth. The teeth then absorb the fluoride varnish, strengthening the enamel and helping prevent cavities.

Who must prescribe the fluoride varnish?

- Dentists;
- Physicians;
- Physician Assistants (PA); or
- Advanced Registered Nurse Practitioners (ARNP).

Who is eligible?

All Medicaid-eligible clients, 18 years of age and younger, may receive fluoride varnish applications. Department of Developmental Disabilities (DDD) clients age 19 and older are also eligible.

Are managed care clients eligible?

Clients whose DSHS Medical ID Cards have an identifier in the HMO column are enrolled in one of HRSA's managed health care organizations. These clients **are eligible for fluoride varnish applications** through fee-for-service. Bill HRSA directly for fluoride varnish applications.

Synagis (CPT code 90378)

To receive payment for Synagis®, you ***must*** do one of the following:

- Include the 11-digit National Drug Code (NDC) on the claim form when billing HRSA for Synagis® purchased by the provider and administered to the client in the provider's office. Continue to bill using CPT code 90378 for the drug itself. Bill one (1) unit for each 50 mg of Synagis® used.

- OR -

- Obtain Synagis® from a HRSA-contracted specialty pharmacy. The pharmacy will bill HRSA directly for the drug and ship it to the provider's office for administration. Providers may then bill HRSA for the administration only. Do not bill HRSA for the drug itself when the drug is billed by the specialty pharmacy. Please check with the pharmacy regarding whether or not they are contracted to bill HRSA directly as contracted pharmacies change often.

HRSA covers Synagis® for those clients younger than one year of age from December 1 – April 30 of any given year without prior authorization (PA). HRSA requires PA for all other time periods and all other age groups. For details regarding the PA process, refer to Section I of HRSA's current Physician-Related Services Billing Instructions.

National Drug Code Format

- **National Drug Code (NDC)** – The 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The 11-digit NDC is composed of a 5-4-2 grouping. The first 5 digits comprise the labeler code assigned to the manufacturer by the Federal Drug Administration (FDA). The second grouping of 4 digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of 2 digits describes the package size. **[WAC 388-530-1050]**

- The NDC ***must*** contain 11-digits in order to be recognized as a valid NDC. It is not uncommon for the label attached to a drug's vial to be missing "leading zeros." **For example:** The label may list the NDC as 123456789, when, in fact, the correct NDC is ***0***1234***0***56789. Make sure that the NDC is listed as an 11-digit number, inserting any leading zeros missing from the 5-4-2 groupings, as necessary. ***HRSA will deny claims for drugs billed without a valid 11-digit NDC.***

Electronic 837-P Claim Form Billing Requirements

Providers must continue to identify the drug given by reporting the drug's CPT or HCPCS code in the **PROFESSIONAL SERVICE Loop 2400, SV101-1 and the corresponding 11-digit NDC in DRUG IDENTIFICATION Loop 2410, LIN02 and LIN03.** In addition, the units reported in the "units" field in PROFESSIONAL SERVICE Loop 2400, SV103 and SV104 must continue to correspond to the description of the CPT or HCPCS code.

HCFA-1500 Claim Form Billing Requirements

If you bill using a **paper** HCFA-1500 claim form for **two or fewer drugs on one claim form,** you must list the 11-digit NDC in ***field 19*** of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. 54569549100 Line 2 / 00009737602 Line 3

Line	Date of Service	Procedure Code	Charges	Units
1	07/01/06	99211	50.00	1
2	07/01/06	90378	1500.00	2
3	07/01/06	J3420	60.00	1

DO NOT attempt to list more than two NDCs in field 19 of the paper HCFA-1500 claim form. If you bill for more than 2 drugs, you must list the additional drugs on additional claim forms. **You may not bill more than 2 drugs per claim form.**

If the 11-digit NDC is missing, incomplete, or invalid, the claim line for the drug or supply will be denied.

Using the On-line General Store

1. Go to the Department of Printing website at www.prt.wa.gov.

2. Click ***General Store***. Register if you are new to the site or sign in. Write down your login for future use.

3. You will be given an option to shop by agency or item type. Click ***Shop by Agency***.

4. Click ***Department of Social and Health Services***, then ***Health and Recovery Services Administration***, then ***Publications*** or ***Forms*** whichever is the product you wish to order. You will then have a list of publications or forms by number.

5. Select the item you wish and place it in your shopping cart by clicking on ***Add to Cart***.

   VERY IMPORTANT!! YOU MUST click on the ***Update Cart*** button located below your list of items in your cart. If the button is not visible due to multiple items being in your cart, use the scroll buttons on the right to scroll down until it is visible. If you do not click on the ***Update Cart*** button, you will only receive 1 of each item ordered.

6. You may continue shopping and adding items to your cart, or you may click the ***Check Out*** button.

7. Enter your shipping information on the next screen. Be sure the first time you use the cart you enter your primary shipping information. This will be Address 1 and the default information that will appear each time you check out. You may add other addresses by selecting ***New Address*** in the "Select Address" window and filling in the information. Write down what the new address number is and you can have it automatically filled in by choosing that address number. Then click the ***Total*** button.

The preferred method of ordering is on-line through the Department of Printing's General Store. You may also send orders by email to fulfillment@prt.wa.gov, by phone at 360.586.6360, or fax at 360.586.8831. Please order online if at all possible.

Useful web addresses:

HRSA Publications website http://maa.dshs.wa.gov/CustomerPublications/

DSHS Forms http://www1.dshs.wa.gov/msa/forms/

EPSDT MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT REFERRAL INDICATORS

Consider these and other symptoms/behaviors when making a referral for an assessment.

Category	Indicators for a Mental Health Assessment	
Family	problems separating physical abuse or neglect psychological abuse sexual abuse domestic violence divorce/separation chronic physical or mental illness of parent	drug using or alcoholic parent parental discord few social ties problems with siblings death of parent/sibling parents in criminal justice system
Peer activity	no confidence social isolation	fighting and bullying
Behaviors	temper tantrums fire setting stealing tics sexually acting out lying substance abuse destroys property aggressive	over activity in trouble with law impulsive attachment problems in infants overly compliant to passive defiant running away truancy
School	school failure school refusal	absenteeism or truancy
Feelings	anxiety or nervousness feeling depressed low self-esteem	fearful suicidal
Thoughts	delusions hallucinations	incoherence self-destructive thoughts
Somatic symptoms	trouble sleeping sleepwalking night terrors	enuresis encopresis eating disorder
Social	lack of housing frequent moves financial problems	sexual abuse foster care history of detention
Growth and Development	slow weight gain nonorganic failure to thrive mentally retarded learning disabilities	language delay attention problems speech problems

Derived from a Word Health Organization, primary care child oriented classification system. Haeres, S.M., Leaf, P.J., Leventhal, J.M., Forsyth, B. and Speechley, K.N. (1992), Identification and management of psychosocial and developmental problems in community-based. Primary care pediatric practices. Pediatrics, 89(3), 480 - 485.

The indicators listed above may be elicited from caregivers and children through interviews described in professional references (e.g., American Academy of Pediatrics: Guidelines for Child Health Supervision; and the Region X Nursing Network: Prenatal and Child Health Screening and Assessment Manual). It may be appropriate to interview the child separate from the caregiver beginning at age eight years.

Screening infants and toddlers for mental health problems is an emerging science. Based on professional judgment, referral is appropriate when there are concerns that a family and social environment do not support the infant's mental wellness.

Children with behaviors not listed on the checklist should also be referred for mental health services, if the parent desires. It is important to remember that if the child or parent sees the behavior or symptom as problematic, make a referral, even if the issues seem minor or within "normal" range to you. Parents' and teachers' perceptions have been shown to be the best predictors of mental health problems.

WA State Regional Support Networks (RSNs)

For a complete listing of Washington State RSNs, visit the Mental Health Division's web site at: http://www1.dshs.wa.gov/mentalhealth/rsnmap.shtml

Denotes Change

Billing

Use the appropriate diagnosis code when billing any EPSDT screening service, CPT codes 99381-99395 (e.g., V20.2).

Bill for services such as laboratory work, hearing tests, x-rays, or immunization administration, using the appropriate procedure code(s), along with the screening (CPT codes 99381 - 99395) on the same HCFA-1500 claim form.

When physicians and ARNPs identify problems during a screening examination, they may treat the client or may refer the client to another provider. Physicians and ARNPs are not limited to the procedure codes listed in HRSA's *EPSDT Billing Instructions*. They may also use HRSA's *Physician-Related Services (RBRVS) Billing Instructions* as necessary. Any office, laboratory, radiology, immunization, or other procedure rendered as part of follow-up treatment **must be billed** on a **SEPARATE** HCFA-1500 claim form from the screening examination.

What is the time limit for billing? [Refer to WAC 388-502-0150]

- Providers must submit initial claims and adjust prior claims in a timely manner. HRSA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in HRSA's billing instructions.

- Providers must submit their claim to HRSA and have an Internal Control Number (ICN) assigned by HRSA within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders HRSA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

> **Note:** If HRSA has recouped a plan's premium, causing the provider to bill HRSA, the time limit is 365 days from the date of recoupment by the plan.

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.
Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

- HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  ✓ DSHS certification of a client for a retroactive[2] period; or
  ✓ The provider proves to HRSA's satisfaction that there are other extenuating circumstances.

- HRSA requires providers to bill third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to HRSA's billing limits.

- Providers may **resubmit, modify, or adjust** any timely initial claim, ***except*** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: HRSA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill HRSA, the claim will be denied.

  Note: Newborns of clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen for the newborn.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

Third party liability

You must bill the insurance carrier(s) indicated on the client's Medical ID card. An insurance carrier's time limit for claim submissions may be different than HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA; and
- Attach the insurance carrier's statement.

If you are rebilling, also attach a copy of the HRSA *Remittance and Status Report* showing the previous denial.

If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the **Comments** field of the Electronic Media Claim (EMC).

Third-party carrier codes are available via the Internet at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

Fee Schedule

The EPSDT Fee Schedule is now located in the appendix. To view or download the Fee Schedule, click Appendix.

Immunizations

Immunizations covered under the EPSDT program are listed in the Fee Schedule. For those vaccines that are available at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and under, HRSA pays only for the administration of the vaccine and not for the vaccines themselves. These vaccines are identified in the Comments column of the Fee Schedule as "free from DOH."

You must bill for the administration of the vaccine and for the cost of the vaccine itself as explained in this section.

Clients 18 years of age and younger – "Free from DOH"

- These vaccines are available at no cost from DOH. Therefore, HRSA pays only for administering the vaccine.

- Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90707 SL). **Effective July 1, 2006,** HRSA pays $5.96 for the administration for those vaccines that are free from DOH and are billed with modifier SL (e.g., 90707 SL).

- DO NOT bill CPT codes 90471-90472 or 90465 – 90468 for the administration.

Clients 18 years of age and younger – "Not free from DOH"

- Bill HRSA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with these vaccines. HRSA pays for the vaccine using HRSA's maximum allowable fee schedule.

- Bill HRSA for the vaccine administration using either CPT codes 90465-90468 or 90471-90472. ***Do not*** bill CPT codes 90465 – 90468 in combination with CPT codes 90471-90472. HRSA limits payment for immunization administration to a maximum of two administration codes (e.g., one unit of 90465 and one unit of 90466, one unit of 90467 and one unit of 90468, or one unit of 90471 and one unit of 90472).

  Note: HRSA pays for administration codes (90465 – 90468) ***only*** when the physician counsels the client/family at the time of the administration and the vaccine **is not** available free of charge from the Health Department.

- Providers **must** bill administration codes on the **same** claim form as the procedure code for the vaccine.

Clients 19-20 years of age – All Vaccines

- Bill HRSA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients 19-20 years of age, regardless of whether the vaccine is available free-of-charge from DOH or not. HRSA pays for the vaccine using HRSA's maximum allowable fee schedule.

- Bill for the administration using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Payment is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

Health & Recovery Services Administration (HRSA)
EPSDT Fee Schedule
Effective July 1, 2006

Code Status Indicator	Code	Mod	Maximum Allowable NFS	Maximum Allowable FS	Foster Care Clients/Must use Mod 21	PA?	Comments
R	99201	HA	$34.30	$22.05			
R	99202	HA	$60.55	$43.40			
R	99203	HA	$90.30	$66.85			
R	99204	HA	$127.40	$99.05			
R	99205	HA	$162.05	$132.30			
R	99211	HA	$20.30	$8.40			
R	99212	HA	$36.05	$22.40			
R	99213	HA	$49.00	$32.90			
R	99214	HA	$77.00	$54.95			
R	99215	HA	$111.65	$87.85			
R	99381		$78.75	$56.70	$120.00		
R	99382		$87.15	$55.65	$120.00		
R	99383		$90.65	$59.15	$120.00		
R	99384		$97.65	$66.15	$120.00		
R	99385		$99.75	$67.55	$120.00		
R	99391		$60.20	$40.95	$120.00		
R	99392		$68.95	$49.00	$120.00		
R	99393		$72.80	$52.50	$120.00		
R	99394		$79.80	$59.50	$120.00		
R	99395		$82.60	$60.90	$120.00		

For all other payable procedure codes refer to the Physician-Related Services Fee Schedule
For all payable drugs and biologicals, refer to the Injectable Drug Fee Schedule

Status Indictors
D = Discontinued Code
N = New Code
P = Policy Change
R = Rate Update
# Not Covered in this program

Legend
PA= Written Fax Prior Auth
EPA = Expedited Prior Auth
LE = Limitation Extension
B.R. = By Report
A.C. = Acquisition Cost